STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 00 B. WING	05/08/2012

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: May 1, 2, 3, 4, 7 & 8, 2012 Facility number: 000001 Provider number: 155001 AIM number: 100275310 Survey team: Lori Brettnacher RN, TC Diana Zgonc RN Connie Landman RN Christi Davidson RN Census bed type: SNF/NF: 169 Total: 169 Census payor type: Medicare: 8 Medicaid: 110 Other: 51 Total: 169 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review 5/16/12 by Suzanne Williams, RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for 3 of 19 residents reviewed for care plan development regarding community discharge (Resident #47), dental services (Resident #106), and refusal of care (Resident #166). Findings include: 1. Resident #106's record was reviewed on 5/4/2012 at 9:22 A.M. Resident #106 had current diagnoses which included dementia with	F0279	RE: F279 1. The care plans for Resident #47 (community discharge), Resident #106 (dental services), and Resident #166 (refusal of care) will be reviewed and updated by the appropriate personnel. {See attachment A, B, & C} 2. Due to this plan of correction which includes inservice	05/30/2012

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	paranoia, Alzheimer's disease, congestive heart failure, diabetes II, coronary artery disease, and hypertension. During an interview on 5/1/2012 at 3:11 P.M., Resident #106's son and POA (Power of Attorney) indicated his father was hard of hearing and did not speak English. Resident #106's son indicated his father could not eat in his room because he might choke. Resident #106's son stated, "It would help if he would wear his dentures. I don't know if they ask him to wear them and I am not sure if he would, but I wish they would at least try." During an observation at this time, Resident #106 did not have his dentures in. They were observed in the denture cup in the bathroom. During observations on 5/2/2012 at 10:50 A.M., 5/3/2012 at 9:00 A.M., and 5/4/2012 at 9:15 A.m., Resident #106 was not wearing his dentures. Resident #106's current care plan was reviewed on 5/4/2012 at 9:22 A.M. The current care plan failed to address any issues with Resident #106 refusing care including refusal to wear his dentures. Review of an annual minimum data		education and chart audits, it is unlikely that other residents will have the potential of being affected by this same deficient practice. Nevertheless, ongoing care plan audits, prior to and during care plan meetings, will focus on this deficient practice. 3. Staff inservices to address this deficient practice will take place by 5/30/12. {See attachment D & E}. All departments responsible for developing and monitoring resident care plans will participate in these inservices. Prior to and during care plan meetings, care plans will be reviewed and audited to assure that all resident care plans are comprehensive and include residents problems, goals, issues, refusals of care, etc. 4. As a result of ongoing care plan audits, under the supervision of the Assistant Director of Nursing and the Director of Social Services, any observations or trends of further deficient practices will be immediately addressed and reported at the Quality Improvement Committee Meetings. Any specific follow-up intervention including disciplinary action, policy development, inservice education, care plan	

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	assessment tool dated 1/8/2012 indicated Resident #106 had a memory problem, did not have any behaviors or rejection of care behaviors and required assistance and/or oversight with activities of daily living. Review of a nurse's note dated 4/10/2012 indicated Resident #106 was coming down the hall from the main dining room staggering and gasping for air. His hands were around his neck. This writer ran down the hall. Resident #106 was unable to speak. His color was pale. The Heimlich maneuver was performed for approximately five minutes until the object was dislodged from his airway. A large sized piece of chicken was coughed up onto floor. During an interview on 5/4/2012 at 12:38 P.M., RN #4 (Registered Nurse) indicated she was unable to find a plan of care or documentation of Resident #106 refusing to wear his dentures. During an observation at this time Resident #106 was observed to not be wearing his dentures. 2. The record for Resident #47 was reviewed on 5/7/12 at 9:40 A.M. Current diagnoses included, but were		revisions, etc., will be implemented and monitored as necessary. 5. Date of Completion: 5/30/12	

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	not limited to, schizo-affective disorder, HTN (hypertension), hyperlipidemia, osteoarthritis, edema, dementia, saddle embolus, and GERD (gastroesophageal reflux disease). Resident #47 was admitted to the facility on 12/8/11. The admission Social Service note, dated 12/8/11, indicated the resident was admitted to the facility for "...a 30 day respite stay..." The current health care plan, dated 12/8/11 and last reviewed on 3/8/12, addressed the resident's problem as being a new admission. Interventions included, but were not limited to, welcome to facility, introduce self and explain role, introduce to staff and peers, orient to room and facility, and establish routines. An e-mail, provided by the Administrator on 5/7/12 at 1:30 P.M., dated 2/6/12 at 10:44 A.M., sent by a case manager at CICOA (Central Indiana Council on Aging) indicated "... indicated (resident's name) will be there until at least mid May. I would anticipate this is likely to be long term placement."			

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	A Social Service note on the Care Plan Review form, dated 3/14/12, indicated the resident was adjusting well to the unit and facility, and still uncertain about returning home. The current care plan lacked any documentation of the resident becoming long term care as opposed to respite care. On 5/7/12 at 12:25 P.M., during an interview, SS (Social Services) #7 indicated there was no care plan for discharge planning or for potential for long term placement. She also indicated she had just spoken to the resident's granddaughter who had said she hadn't decided yet if she was going to keep grandmother in the facility as her (granddaughter's) health wasn't very good right now. 3. The record for Resident # 166 was reviewed on 5/4/12 at 9:30 A.M. Diagnoses for Resident # 166 included, but were not limited to, debility and chronic obstructive pulmonary disease. The current physician's orders originally dated 3/27/12 indicated Resident # 166 was prescribed Suboxone 8-2mg (for pain) and take 1			

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	tablet sublingually three times a day. During observation of medication pass on the 2A unit on 5/4/12 at 8:45 A.M., RN # 6 provided the resident with Suboxone 8-2mg along with her other scheduled 9:00 A.M. medications. At this time it was observed that Resident # 166 swallowed all medications from the container. The record lacked documentation the physician was aware the resident was swallowing the medication and lacked a care plan the resident refused to take the medication as prescribed. During an interview with RN # 6 on 5/7/12 at 9:10 A.M., she indicated she knew the resident was not taking the medications as ordered but they had talked to the resident and she refused to allow the medication to dissolve, she just swallows it with the rest of her medications. During an interview with Resident # 166 on 5/7/12 at 3:15 P.M., she indicated she was aware the medication was supposed to be taken sublingually and the nurses had educated her with that information but it was her choice to take the			

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	medication the way she way she wanted to and that was to swallow it. During an interview on 5/7/12 at 3:30 P.M. with the Director of Nursing, she indicated there was not a care plan for the resident's refusal to take the medication as prescribed by the physician. 3.1-35(a)			

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F0334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;			

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	(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. Based on record review and interview, the facility failed to ensure documentation of education regarding annual flu vaccinations was provided to residents or their responsible parties annually for 4 of 5 residents reviewed for flu vaccinations in a Stage 2 Sample of 36 (Residents #18, #85, #106, and #171). Findings include: The following records were reviewed on 5/7/12 at 2:00 P.M. Resident #18 received the flu vaccine	F0334	F334 1. There have been no residents found to have been affected by this deficient practice. 2. Due to this plan of correction which will include policy review / development {See Attachment F} the development of an Influenza / Pneumococcal Immunization chart sticker system {See Attachment G}, and an annual mailing and distribution of a fact	05/30/2012

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	on 10/18/11. The consent for the flu vaccine was signed on 10/13/09. The record lacked documentation of education concerning the flu vaccine being provided to the resident or responsible party prior to the annual vaccine being administered. Resident #85 received the flu vaccine on 10/18/11. The consent for the administration of the vaccine was signed on 6/21/05. The record lacked documentation of annual education being provided to the resident or responsible party prior to the annual vaccine being administered. Resident #106 received the flu vaccine on 10/17/11. The consent for administration of the flu vaccine was signed on 4/30/07. The record lacked documentation of education being provided to the resident or responsible party prior to the administration of the annual vaccine. Resident #171 received the flu vaccine on 10/17/11. The consent for the administration of the flu vaccine was signed on 2/18/10. The record lacked documentation of education being provided to the resident or responsible party prior to the administration of the annual flu vaccine.		sheet including the benefits and potential side effects of such immunization it is unlikely that other residents will have the same potential of being affected by this same deficient practice. 3. Corrective actions for this deficient practice will include policy review / development, development of an immunization chart sticker system, and annual mailings and distribution of immunization fact sheets will all be implemented and closely monitored by Nursing Administration, Unit Managers, and Nursing Supervisors. 4. This deficient practice and the implemented corrective actions will be monitored on a regular basis by Nursing Administration, Unit Managers, and Nursing Supervisors. Any observations or trends of further deficient practices will be immediately addressed and reported at the Quality Improvement Committee Meetings. Any specific follow-up intervention including disciplinary action, policy development, inservice education, etc., will be implemented and monitored as necessary.	

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	During an interview with the DON (Director of Nursing) on 5/7/12 at 3:30 P.M., she indicated she was unable to provide documentation the residents or responsible parties were given education and information regarding the flu vaccinations prior to the annual flu vaccination administration. A current facility policy, dated 1/30/12, titled "Influenza and Pneumococcal Immunization Policy", provided by the Administrator on 5/1/12 at 2:30 P.M. indicated: "... Informed consent for influenza and pneumococcal immunization ... 7. In addition, the resident and/or responsible (sic) will be provided with Public Influenza and Pneumococcal Vaccine Information Statements from the Centers for Disease Control and Prevention (CDC)." 3.1-13(a)		5. Date of Completion: 5/30/12	

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F0371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on record review, observation and interview, the facility failed to serve food in a sanitary manner as evidenced by a certified nursing assistant [CNA] not washing hands and changing gloves after touching a resident before serving the next resident the lunch meal, and a CNA touching resident's bread with bare hands for residents eating in 2 of 4 dining areas observed. Findings include: 1. During a meal observation on 05/01/12 at 12:15 p.m., CNA #1 received a lunch cart from the main kitchen. Eight residents were observed in the small dining area in the far left wing of Unit 1C. CNA #1 was wearing a hair net, an apron and disposable gloves. CNA #1 removed a tray from the cart and set it on the counter. The CNA removed the plastic lid from the soup bowl, removed silverware from the plastic wrapping, and delivered the tray to a	F0371	F371 1. There have been no residents found to have been affected by this deficient practice. 2. Due to this plan of correction which will include policy review / development {See Attachment H}, staff disciplinary action for C.N.A #1 and C.N.A. #2 {See Attachment I}, and inservice education {See Attachment J-content} and {See Attachment K-attendance}, it is unlikely that other residents will have the potential of being affected by this same deficient practice. 3. Inservice education will take place during the week of May 21, 2012. During these inservices, this deficient practice will be communicated to the staff and	05/30/2012

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	resident. The CNA returned to the cart and removed another tray, removed the silverware from the plastic wrap, cut up the chicken, and served the tray. The CNA continued with removing trays and setting up the trays and serving the residents. CNA #1 was observed touching a resident's shoulder to arouse the resident, giving the resident a bite of chicken with a fork, and returning to the cart to set up trays for the remainder of the residents. During the service observation, the CNA did not wash hands or change gloves. 2. During a meal observation in a small dining area on Unit 1B on 05/01/12 at 12:36 p.m., CNA #2 was observed touching a resident's slice of bread with bare hands. CNA #2 touched the resident's shoulder and left the dining area to get a cup of water. CNA #2 re-entered the area with a cup of water and did not wash hands. During an interview with the unit manager of Unit 1C on 05/04/12 at 10:00 a.m., the Unit Manager #5 indicated staff should change gloves and wash hands between touching a resident and serving trays. A facility policy provided by the		"hand hygiene for meal service on nursing unit" procedures with return demonstrations will occur. In addition, "Hand Washing for Healthcare Workers" {See Attachment L} will continue to be provided for all staff and attached to employee name badge lanyards. 4. Nursing Staff, Unit Managers, Nursing Administration, Food Service Management, and Infection Prevention Nurse will all be responsible for ongoing supervision and monitoring of this deficient practice. Any observations or trends of further deficient practices will be immediately addressed and reported at the Quality Improvement Committee Meetings. Any specific follow-up intervention including disciplinary action, policy development, inservice education, etc., will be implemented and monitored as necessary. 5. Date of Completion: 5/30/12	

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	Assistant Director of Nursing on 05/08/12 at 10:53 a.m. and dated as revised on 10/09, indicated, "...Hands shall be washed at the following times and in accordance with regulatory guidelines...Staff shall wash their hands at the following times: Before and after direct resident contact...." During an interview on 05/08/12 at 12:41 p.m., the Food Service Manager indicated the individual unit managers were responsible for training and monitoring staff for safe and sanitary food service during meals. A food service policy was requested. A facility policy provided by the Food Service Manager on 05/08/12 at 1:37 p.m., titled, "Dietary Food Handling Policy," indicated, "...Bare hands should never touch raw food directly...Hairnets and gloves are to be worn when serving meals on the serving line or in the MDR [main dining room] when serving residents. Ensure gloves do not come into contact with non-food surfaces (i.e. tables, clothing etc.). Change gloves as necessary and follow department hand-washing policy...." 3.1-21(i)(3)			

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HOOVERWOOD	7001 HOOVER RD INDIANAPOLIS, IN 46260

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on interview and record review, the facility failed to develop an	F0441	F441	05/30/2012

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	Infection Control Policy based on current CDC (Center for Disease Control) guidelines to ensure the transmission of disease and infection from the use of resident shared glucometers for 28 residents requiring blood sugar testing. Findings include: During an interview on 5/4/2012 at 12:40 P.M., Registered Nurse (RN) #4 indicated she believed the glucometers were cleaned every 24 hours but she would have to check the protocol. During an interview on 5/4/2012 at 12:43 P.M., QMA (Qualified Medication Aide) #3 indicated night shift cleaned the glucometers. QMA #3 stated, "We clean it once a shift on nights. No, we don't clean it between residents." RN #4 provided the cleaning logs and confirmed it was cleaned once a shift on nights. During an interview on 5/4/2012 at 1:00 P.M., LPN #8 (Licensed Practical Nurse) stated, "The machine is cleaned daily on night shift. We use alcohol swabs to wipe them off between residents." During an interview on 5/4/2012 at		1. There have been no residents found to have been affected by this deficient practice. 2. Due to this plan of correction which will include policy development {See Attachment M}, inservice education {See Attachment N-content} {See Attachment O-attendance}, and Professional Development Program Log for Infection Prevention Coordinator {See Attachment-P}, it is unlikely that other residents will have the same potential of being affected by this same deficient practice. 3. Inservice education on this deficient practice has and will continue to take place. This topic also continues to be addressed in new employee orientation. This inservice will include the presentation of a revised policy on the Cleaning and Disinfection of the Blood Glucometer. The inservice will also include demonstration of the required cleaning and disinfecting process. To assure that Hooverwood and our Infection Prevention Coordinator is up to date on the very latest infection prevention standards, a	

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	1:02 P.M., the Administrator indicated the glucometers were cleaned per the manufacturer's recommendations. The Administrator provided the manufacturer's recommendations on 5/4/2012 at 1:08 P.M. Review of the manufacturer's recommendations indicated contact with blood presented a potential infection risk. The recommendations suggested cleaning the meter between patients. Instructions on how to clean the glucometers indicated the outside of the meter should be cleaned with a lint-free cloth. Dampen with soapy water or isopropyl alcohol (70-80%). To disinfect the meter, dilute one ml (milliliter) of household bleach (5% -6% sodium hydrochloride solution) in nine ml of water. This is a 1:10 dilution. The final concentration is 0.5-0.6% sodium hydrochloride. A document titled "ARKRAY Important Product Information Regarding Cleaning and Disinfecting Blood Glucose Meters" dated October 14, 2012 and provided by ADON #9 on 5/4/2012 at 1:35 P.M. indicated: It is ARKRAY's policy to advise healthcare professionals to clean and disinfect blood glucose meters between each resident test to avoid cross contamination issues. For		"Professional Development Program" has been implemented. On a monthly basis (and more frequently as necessary), the Infection Prevention Coordinator will document her review of monthly Indiana State Department of Health, Center for Disease Control, and other professional newsletters, websites, conferences, etc. 4. The Unit Managers, Nursing Supervisors, Nursing Administration, and the Infection Prevention Coordinator will all be responsible for making routine and unannounced observations of the cleaning and disinfecting of the blood glucometer devices. Any observations or trends of further deficient practices will be immediately addressed and reported at the Quality Improvement Committee Meetings. Any specific follow-up intervention including disciplinary action, policy development, inservice education, etc., will be implemented and monitored as necessary. 5. Date of Completion: 5/30/12	

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	more information on CMS's F-Tag 441 Guideline on Infection Control go to http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html or www.fda.gov/MedicalDevices/Safety/AlertsandNotices/ucm224025.htm." Review of the facility's current policy provided by the administrator on 5/4/2012 at 1:08 P.M. indicated the following: 1. In between each resident test, clean the meter according to the manufacturer's recommendations. 2. If the meter is visibly soiled or should become contaminated with body fluid, immediate disinfection should be done according to the manufacturer's recommendations. The policy lacked content which reflected current recommendations from the Center For Disease Control. During an interview on 5/4/2012 at 1:10 P.M., the Director of Nursing (DON) indicated she expected her staff to do it however they were taught, trained, and inserviced by the Infection Control Nurse. During an interview on 5/4/2012 at 1:10 P.M., the Infection Control Nurse indicated she expected the staff to follow their training and they were			

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	trained to follow the manufacturer's instructions. During an interview on 5/4/2012 at 1:10 P.M. ADON (Assistant Director of Nursing) #9, indicated the staff cleaned the meters according to the Arkay manual which indicated alcohol swabs should be used between residents. The meters were cleaned twice a day with the sani-wipes in the white jugs. The ADON indicated they did not have documentation of specific training, only check off lists that showed staff had been trained on glucometers. During an interview on 5/4/2012 at 1:10 P.M., the DON, ADON, and the Infection Control Nurse all indicated as far as they knew cleaning with alcohol was sufficient between resident glucometer use. They indicated they were not aware of the current CDC (Center Disease Control) recommendations for the prevention of disease and infection regarding shared glucometer use and the need for cleaning and disinfecting between resident use. On 5/4/2012 at 1:30 P.M. the current Center for Disease Control guidelines regarding prevention of disease transmission with glucometers were			

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	reviewed. The current CDC guidelines indicated the following: The Centers for Disease Control and Prevention (CDC) has become increasingly concerned about the risks for transmitting hepatitis B virus (HBV) and other infectious diseases during assisted blood glucose (blood sugar) monitoring and insulin administration. Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared. During an interview on 5/8/2012 at 10:30 A.M., the DON (Director of Nursing) indicated currently there were twenty-eight residents living in the facility which required blood sugar testing utilizing the shared blood glucose meters. 3.1-18(b)			